UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Cialis (tadalafil)

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

FAX FORM AND RELEVENT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

Criteria for Approval (ALL of the following criteria must be met):

- ❑ Diagnosis of Benign Prostatic Hyperplasia described in chart note. Chart note #:_____
- ❑ Medication is not prescribed for the treatment of Erectile Dysfunction.
- ❑ Trial and failure or contraindication of at least one preferred alpha-1 antagonist or 5 alpha-reductase inhibitor:
  - Medication used: _____
  - Duration of use: _____
  - Details of Failure / Contraindication: _____
  - Chart Note Page #: _____

NOTE:

- ❖ This Prior Authorization **ONLY** applies to Cialis (tadalafil) specific NDCs used for Benign Prostatic Hyperplasia (BPH). Please use Pulmonary Arterial Hypertension Prior Authorization form for Alyq and Adcirca (tadalafil) NDCs.

- ❖ Per federal regulation, Medicaid does not reimburse for drugs used for the treatment of sexual dysfunction or erectile dysfunction. Cialis prescriptions for Benign Prostatic Hyperplasia should have that diagnosis included on the prescription and pharmacies should dispense only those Cialis (tadalafil) NDCs with the BPH indication.

Re-authorization Criteria:
Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.

Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date